Stone Creek Family Medicine

AUTHORIZATION FORM
For Release of Protected Health Information

By signing this form, I authorize you to use and disclose the protected health information described below.

Patient Name: ____DOB:__________________

The health information you may release subject to this authorization is as follows:

☐ Complete Medical Records	☐ Laboratory Tests	☐ Prescriptions/Samples
☐ Consultation Reports	☐ Radiology Reports	☐ Speak To Over Phone
☐ Progress Notes	☐ Physicians' Orders	☐ ALL OF THE ABOVE

If **OTHER,** please specify:____

Release my protected health information the following person(s)/entity:

Name:____ Relationship to Patient: ____________

Street:______________ City: ________State:___ Zip:______ Phone #:______________________

This authorization shall be in force and effective indefinitely unless specified below with a term date or term event:_______________________________________

☐ **I DO NOT GIVE PERMISSION FOR YOU TO RELEASE MY INFORMATION TO ANYONE.**

I understand that I have the right to revoke this authorization in writing at any time by sending a written notification to the following clinic address:

Stone Creek Family Medicine
19782 Hwy 105 W. Suite 111
Montgomery, TX 77356
Phone # 936-582-0220
Fax # 936-582-0222

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPPA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

____ ________________________
Signature of Patient or Authorized Representative Date

____
Print Name of Patient or Authorized Representative